AGING AND DISABILITY SERVICES ADMINISTRATION
OMNIBUS BUDGET RECONCILIATION ACT (OBRA)
NURSING ASSISTANT TRAINING PROGRAM
PO BOX 45600
OLYMPIA WA 98504-5600

APPLICATION FOR OBRA PROGRAM APPROVAL (NATCEP)

DATE OF APPLICATION

LEGAL NAME OF SPONSORING HEALTH CARE FACILITY, HOSPITAL, SCHOOL OR OTHER ENTITY				TELEPHONE NUMBER (INCLUDE AREA CODE) ( )
MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE
STREET ADDRESS IF DIFFERENT FROM MAILING ADDRESS	CITY	STATE	ZIP CODE	E-MAIL ADDRESS
NAME OF FACILITY ADMINISTRATOR, VOCATIONAL DIRECTOR, DEPARTMENT HEAD, OR CHIEF ADMINISTRATIVE OFFICER				
NAME OF PROGRAM DIRECTOR, NURSING ASSISTANT TRAINING PROGRAM				CONTACT TELEPHONE NUMBER (INCLUDE AREA CODE ( )

If facility was approved for Nursing Assistant Training previously, what is your training program approval number?

Number of hours proposed for your Nursing Assistant Training Program: Classroom _____ Clinical _____ Total Hours: _____

The following attachments are required for all programs. ATTACH THE FOLLOWING TO THIS APPLICATION.

☐ 1. Application for OBRA Program Director, DSHS 14-370

☐ 2. **Instructional Staff Applications, DSHS 14-369.** This is not applicable if the program director is the sole instructor.

☐ 3. The **curriculum outline and schedule of class and clinical presentations**. The applicant must provide evidence of content that will lead to the achievement of all required nursing assistant competencies listed in 42CFR 483-152.

☐ 4. The **skills checklist** used in your program for skills achievement verification.

I _____ representing _____ do
Name of signing party (print) Name of applying entity

Hereby acknowledge my understanding that the approval process for a nursing assistant training program requires approval by the Department of Social and Health Services, before classes can be offered. I further understand that I must notify the Department of Social and Health Services whenever significant changes to the training program occur in personnel, classroom location, etc.

_____ _____
Signature Date